

Superior Dental Care Office Quick Reference

Inquiries

View a summary of benefits by entering the plan number listed on the ID card into the search field in the top right corner at **SuperiorDental.com**.

Participating providers can also access eligibility, benefits and claims using **Superior Direct Connect**.

SDC's Dentist & Member Services team is available Monday-Friday, 7:30am-5:00pm EST at **1-800-801-4915**.

Claim Submissions

Superior Dental Care
P.O. Box 6018
Cleveland, OH 44101-1018

For electronic submissions, use **Payor ID 31117**

Note: Supporting documents accepted using NEA attachments/reference number only.

Service	Claim Requirement
Palliative	<ul style="list-style-type: none"> narrative
Gingival Scaling or Debridement	<ul style="list-style-type: none"> narrative date of last prophylaxis
Scaling and Root Planing	<ul style="list-style-type: none"> pre-op full mouth perio chart including mobility*
Perio Maintenance	<ul style="list-style-type: none"> date of most recent SRP or osseous surgery
Restorations	<ul style="list-style-type: none"> for multiple anterior or 6 or more posterior, diagnostic quality pre-op x-ray*
Crowns on Natural Teeth	<ul style="list-style-type: none"> initial placement or date of prior placement prep date and seat date diagnostic quality pre-op x-ray* for all out of network claims or for in network claims with 2 or more crowns
Crowns over Implants	<ul style="list-style-type: none"> initial placement or date of prior placement impression date and seat date complete chart of missing teeth* if pre-existing crown or bridge, date of prior placement
Bridges	<ul style="list-style-type: none"> initial placement or date of prior placement prep date and seat date complete chart of missing teeth* if other bridges in arch, provide date of placement, condition/pending treatment
Partials	<ul style="list-style-type: none"> initial placement or date of prior placement impression date and delivery date complete chart of missing teeth*
Dentures	<ul style="list-style-type: none"> initial placement or date of prior placement impression date and delivery date complete chart of missing teeth* if pre-existing partial, date of prior placement

*Patient Name and Date must be visible on all x-ray images and tooth/perio charting. Additional documentation may be requested by SDC's Dental Consultants to complete review of submitted services. Visit **SuperiorDental.com** for additional submission guidelines.